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Special Article

Management and Marketing in Health Care

Some Lessons for the United States from the British System

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The British health care system has been examined by sociologists, political scientists, and medical care specialists before, but in this presentation a section of the British health care system is viewed through the eyes of modern business management, particularly as to cost and consumer effectiveness. Examination of positive features as well as problems may be helpful in relation to some future health care delivery system in the United States. Cross fertilization between the disciplines of management and medicine has much to offer to the rapidly changing delivery of health care in the United States.

PREFACE: This article is an interdisciplinary effort. Robert Gumbiner, MD, executive director of Family Health Program, visited the British Isles to study the ambulatory care system. His orientation is that of the chief executive of an existing prepayment group practice (HMO) and includes over 15 years of experience in the management of ambulatory care facilities. He combines academic input as Adjunct Professor and director of the program in Management of Health Care Delivery Systems at California State University at Long Beach. Dr. Gumbiner's observations were then combined with those of Robert Frye, Doctor of Business Administration and Professor of Management, California State University at Long Beach, in order to bring to bear on the problems facing the ambulatory care system in Scotland and Ireland an additional orientation and expertise.

A review of the history and current status of the British system reveals that, in many respects, it has advanced beyond the United States system, both in theory and practice. In fact, some facets of the British experience could well serve as a guide for the evolution of our health care delivery system.

THE SCOPE OF THIS REPORT is limited to the ambulatory care section of the British health care system, principally in Scotland and Northern Ireland. This represents a deliberate attempt to obtain insight into these smaller, more flexible units which appear to represent some of the most advanced elements of change.

It appears that the British system is confronted by a number of philosophical obstacles to the evolution of an optimally effective health care system. However, a reorientation of thinking to managerial and marketing basics would go a long way toward overcoming these obstacles.

There are lessons in all this for legislators, planners, and providers as they attempt to design a

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system for the United States. These lessons are particularly pertinent because of the context in which the British and United States systems have developed. The British forthrightly did something that the United States, with its massive resources, has failed to do. In 1948, with less medical manpower and money per capita than the United States, Britain simply legislated a new health care delivery system and made it work—at least within the constraints that were imposed by uncontrollable conditions. On the other hand, the legislative and executive branches in the United States have been complaining about our ineffective system for years—yet have done little more than nibble around the edge of the problem with stop-gap measures that can, at best, only shore up a failing system piecemeal.

History and Current Status of the British System

In reviewing the British system, it was deemed most appropriate to study the elements where the bulk of medical care should be administered—the ambulatory care center. In addition, by concentrating on two smaller, self-contained geographic and administrative units of the system—the Scottish Home and Health Service and the Irish Ministry of Health and Social Services—a more comprehensive view of relatively progressive elements was achieved. It appears that there is an inverse relationship between the size of the self-governing unit and its progressiveness.

History of the system. In 1912, the British enacted the National Health Insurance Act. In reality, this was a national health insurance program with somewhat limited care. While it covered most outpatient ambulatory care services, it allowed for very few hospital services. Similarly, while it covered a wide variety of services under a variety of coverage plans, it usually provided only for the employee and not his family. Nor did it provide for the self-employed or the unemployed.

This 1912 legislation gave way, in 1948, to the present National Health Service—an attempt to provide a more comprehensive level of care to the British. Even more important, it was an attempt to deliver this health care to all Britons, whenever and wherever they needed it.

Finally, in 1968, the first British green paper was published. This highly significant advance was a review of the British health system and its progress since 1948. Many of the recent developments in the system can be traced to the remedial measures contained in this paper.

Current status of the system. The British health system is divided into three spheres of authority. One administers the hospital service, including specialists, who are all hospital-based. It also sets pay scales for the specialist sector of the doctor population.

A second section administers local health services and is somewhat akin to our Public Health Service. The Local Health Authority controls health officers, health visitors, and various public health functions such as sanitation, food, well-baby care, and prenatal care.

The final sphere of authority administers ambulatory care, with control over the general practitioner and his services. Further, it administers the capitation and service payments and, as we shall see later, the development of ambulatory care centers.

The Executive Council is an integral part of this general practice section. It is somewhat like our comprehensive health planning councils, but possesses vastly greater powers. Authorized under National Health Service, it is composed of lay citizens and doctors. The Executive Council is charged with the responsibility for, and limited to authority over, general practitioners in its geographic area. It handles complaints and inquiries, and—in a very unstructured manner—attempts to exercise some control over the quality and accessibility of care.

Geographic balance. The most important function of an Executive Council is, in a sense, to license general practitioners to practice in its area. Without Executive Council authorization, an applicant general practitioner can practice in an area only if he chooses to do so outside the National Health Service system. This means that he can receive no payment through the system.

The Executive Council approach represents the British attempt to come to grips with a universal problem in the delivery of health care—the elimination of imbalance between areas that have too many doctors and those with too few. Approval will not be given for new practices in areas that are adequately served. However, in an area where there are too few the doctor will begin with a ready-made panel of patients, or at least with his name listed in the local postoffice as available for assignment of patients.

One of the side benefits of this system is the ease with which the consumer can locate a general practitioner. A visit to the postoffice produces a

list of all available practitioners in the area who have room on their panels.

This mandatory distribution of doctors, as well as consumer accessibility to primary care doctors, represents an impressive advantage over the United States system.

Balance between specialists and general practitioners. The universal problem of imbalance between the services of the general practitioner and the specialist has been attacked directly through application of the great equalizer, money. The general practitioner is provided with an immediate income greater than the average for specialists. Typically, as soon as he gets his medical degree, the general practitioner earns some 4,000 to 5,000 pounds a year. The specialist, on the other hand, must serve a period as a "registrar" in a district hospital. This includes his residency training and beyond, averaging about 15 years—a period during which he starts at about 2,000 pounds a year and reaches a maximum of 3,500 pounds a year several years later. As a registrar, the doctor must wait until a position opens as a "consultant" in order to increase his income. Since the system is not expanding rapidly, his appointment must await the death or retirement of the consultant he is to replace.

The typical general practitioner not only will realize a greater immediate income, over his lifetime he will probably earn more money than a specialist. The specialist still retains greater prestige and presumably, for him, more interesting work.

By this simple device of reversing the usual monetary reward system, the British have gone far in decreasing the trend toward over-specialization and the disappearance of the generalist as we know it in the United States.

Optimum utilization of facilities and management. Perhaps the outstanding feature of the British system, particularly in Northern Ireland and Scotland, is the sincere attempt to bring health care to the consumer by establishing local health centers for the combined use of general practitioners and Local Health Authority personnel. This trend brings together two important elements of ambulatory care into a single facility.

Amalgamation is taking place at a higher organizational level as well, with an effort being undertaken to merge the three sections of the system—hospital, Local Health Authority and ambulatory care—into a more cohesive unit. Ideally, this combined administration would assign tasks to each sphere of influence in accord with its capabilities and assure the most effective utilization of resources in order to eliminate the empire-building inherent in any such tripartite system.

Sporadic attempts have been made in the United States to combine ambulatory neighborhood treatment centers, health departments and county hospitals. We could do well to observe how the British are approaching this on a national scale.

The Ambulatory Care Center

Ambulatory care centers in Scotland range all the way from brand new centers, constructed specifically for ambulatory care and community health services, to a remodeled civil defense building in the inner city of Edinburgh or the ambulatory care section of a district hospital.

Typically, ambulatory care units house seven or eight doctors. However, this is not truly a group practice. Rather, it is a series of small partnerships of two or three doctors who "cover" for one another. The several partnerships simply share the same facilities, and have little in common other than centralized record-keeping, receptionists, and minimal ancillary services.

Although the ambulatory care center is a recent development in the British system, it is highly developed in Northern Ireland where, it is expected, all general practitioners soon will be working from these centers. It is in Ireland that the local health services sector has made the most progress in constructing ambulatory care centers which include quarters for general practitioners, health visitors, the district nurse, the well-baby and prenatal clinic, the nutritional center and some social services.

The contrast between care delivered in a center of this sort and typical health care delivery in the United States is unsettling. In this country, a mother may go to the public health department for well-baby care. Then, if the baby is sick, she may have to travel across town and find a physician to treat the child. In the Irish system, the mother would simply walk across the hall to get treatment for her baby. In these centers, there is valuable interaction among the professionals; for example, doctors can send a health visitor to evaluate a patient in his home, and experts in nutrition and social service counselling are available on the premises.

Several major problem areas exist in the portions of the present British system we examined. Although these same problems exist in the United

States, we were surprised that they still exist in a system that has been operating since 1948. Innovators, as the British have been, of course may be expected to make mistakes; but it is hoped that as the United States develops its health care system, these same errors can be avoided.

Intersectional conflict. The arbitrary tripartite nature of the total system in Britain reduces its effectiveness. Duplication exists in services provided by the general practitioner and also by the local health authority and the hospital section. Problems in coordination and follow-through can be severe, and the competition for funding from the National Health Service among hospital specialists, community health services, and general practitioners creates administrative burdens.

In addition, there appears to be a power struggle between the local health-general practitioner and the hospital-specialist sections of the system. On the one hand, the hospital-specialist section is attempting to capture ambulatory care for the district hospitals. One such attempt involves luring general practitioners into the hospitals and making "ambulatory care specialists" out of them.

On the other hand, the local health-general practitioner section is attempting to integrate specialists, particularly of the primary care type such as pediatricians and internists, and assign them to the ambulatory care centers to provide ongoing consulting services.

A pilot project in Edinburgh is of interest. A simplified x-ray machine is available to some general practitioners who have been trained to use it. However, the hospital-specialist section maintains enough control to keep those same general practitioners from reading even the simplest of the x-ray films that they take.

Administrative personnel should take an objective look at all the different problems and all the different sectors of the delivery of medical care, then make optimal allocation of resources without constantly considering whose domain might be infringed upon, whose power interfered with, whose toes stepped on.

Productivity

The general practitioner's day appears to be rather relaxed. Typically, it was found that the day begins at about 9 o'clock. The period from about 9 to 11 in the morning is spent in consulting with patients in the center. Even here, examinations may not be thorough—one doctor said that he deals with ten patients an hour.

After the morning stint of two hours the doctor spends an hour or so chatting with colleagues, bringing his paperwork up to date (not a great task since the administrative staff seems to be comfortably large—the only one that is), and drinking coffee. Following this, he usually leaves about noon to make home visits until 4 p.m. (There is some evidence that home visits are not overly taxing—the Briton is beginning to accept the idea of visiting the center for treatment rather than having the doctor "drop by.") Finally, the doctor will round off his day with an hour or two from 4 to 5 or 6 p.m. spent back in his office seeing patients.

Despite large panels in some areas, it is unlikely that a physician's panel will contain many more than 2,000 patients. Many general practitioners, in fact, have panels with as few as 1,200—small when one realizes that the general practitioner provides only a portion of each patient's care, other portions being provided by the hospital specialist and the local health authority. This leads an observer to question the productivity of the typical ambulatory care physician.

This points up the unfortunate problem of the lack of control exercised over either the quantity or the quality of medical care that is delivered. The system is spending money without demanding performance from the physician measured against standards. A physician can get away with a three-hour work day and, further, can see either six patients during that time or sixty patients, with no control over either quality or quantity.

This serious question about general practitioners' productivity in the British system goes far beyond a relaxed attitude toward working hours. First, there appears to be minimal utilization of ancillary and paramedical personnel, or even effective use of those few who are present.

Second, the physician's productivity is severely hampered by the lack of laboratory and other aids—basically he is able to do only what he can do with his hands.

At least in concept, the greatest cost in any health care system is the cost of personnel. This does not seem to have had much impact on the British health system administration. Simple installations—x-ray units and laboratories—in ambulatory care centers would save enormous amounts of time for the total system—doctors, ancillary people and consumers. Instead, the British general practitioner can do little more than examine a patient and, if he feels it is necessary, bundle him

off to a district hospital to specialists or for x-ray examination or laboratory tests.

The ponderous course of interaction between consumer, general practitioner and specialist shows clearly the lack of regard for productivity. Despite the inconvenience of traveling, a patient in need of specialists' services, or even simple laboratory tests, is sent off to a district hospital where he may have to wait for hours. Then he returns to his general practitioner, who may have to wait days for a report.

Or the consumer's convenience may be served at the expense of physicians' time: A general practioner asks for consultation, a specialist travels out from the district hospital, and both may visit the patient in his home. This procedure almost invariably takes an entire afternoon of two physicians' time.

A narrow view of cost containment precludes the general practitioner's achieving real productivity. Denying him basic facilities, such as x-ray and laboratory, saves capital expenditures at that center but results in greater total cost through manhours lost. A non-objective element here may be a matter of innate jealousy on the part of specialists who do not want general practitioners to impinge upon their domains.

This inability to understand the principle of making optimal use of all of the elements in a system has adverse effects on the physician himself. Not only is the ambulatory care physician's time not adequately utilized, but his skills also. It seems wasteful that a physician who has training in orthopedics, minor surgery and internal medicine should spend all his working day simply screening minor complaints and shuffiing them off to hospital-based specialists.

Facilities

Whether it is a collection of general practitioners' offices, a combined public health-general practitioner center, or the ambulatory care section of a district hospital, the British ambulatory care center is likely to be poorly designed from a functional point of view even when it is aesthetically pleasing. Although many are new, neat and clean, much space may be devoted to nonfunctional areas such as halls and staff rooms. It appears that the centers have been designed by persons outside of the health care delivery system and without substantial input from the people working in the centers.

In many instances this is obviously true—first the centers were built, then the doctors were lured into them by some rather innovative techniques. One of these techniques calls for the health center physicians to pay rent for their quarters and wages for the ancillary health worker. Then, this money is returned to them in the form of additional incentive pay for using the centers.

An example of a minor sort of problem that complicates fundamental, substantive problems is the relatively crude system of appointments and record-keeping. First, even the concept of patient appointments is a new one in the British system and is handled differently than in the United States. The physician stacks on his desk the records of patients who have appointments, and calls them in one by one from the top down. This obviously allows no provision for late cancellations and walk-in patients, even emergency cases, and provides no system for screening patients by relative need. The records themselves are typically about the size of 3 x 5 file cards, and entries are seldom over one line in length—evidence of deficiencies in quality control and systems management.

The British ambulatory care system appears curiously ambivalent toward ancillary staffing in its ambulatory care facilities. On the one hand, physicians practicing in centers are relieved of substantially all of their paper work and enjoy the services of ample reception staffs. On the other hand, the lack of nursing attendants is startling. Typically, a center will have one or two nursing personnel who administer shots and dressings, but are seldom utilized in assisting a doctor in examination or treatment.

Usually there are no medical group or health center managers. In a few instances a nurse or ancillary with a "few weeks' training" in management was being used—a real lack of sophistication in management method.

Consumer Orientation

Great progress could be made through the proper utilization of services, and proper application of both physicians' and consumers' time.

Consumer orientation for all providers including doctors would probably overcome the present inefficiencies with regard to the use of health center x-ray and laboratory facilities and change the system under which specialists are available only in large district hospitals far removed from the patients they are to serve. Certainly consumer orientation would be a force against centralizing

portions of the ambulatory care system in these major regional hospital centers.

One might argue that the British physician's willingness to make home visits is an example of consumer orientation. By the same token, one might argue that credit and home delivery extended by the corner grocery store would be a sign of consumer orientation. In either instance, the result is a high-cost, less-than-effective operation which can do nothing but raise costs to the consumer, cut down on the quality and availability of products or services, and fail in its mission to provide what it is supposed to provide in an optimum system.

Philosophical Obstacles

There are three major philosophical obstacles to improvement in the British health care system. These are (1) bureaucracy, (2) adherence to tradition, and (3) a lack of consideration of the system in its entirety.

Bureaucracy. As might be expected of a system that has been evolving for two generations, and in a society keenly aware of protocol, there is a substantial bureaucratic structure within the system.

As has been pointed out, the various sections of the bureaucracy have not yet come together with common goals. Although the ambulatory care and the local health sections seem to have gotten themselves together—using the combined health center as a vehicle—the hospital-specialist section seems to be completely unaware of the total concept of providing care to the consumer in the best possible manner.

However, the reverence accorded large hospitals is not confined to the hospital-specialist section. On the contrary, the local health-ambulatory care section management clings to the idea that huge district hospitals are the most effective means of delivering care.

As is typical in a bureaucracy, the concept of consumerism is lost. The bureaucrat tends to lose sight of the consumer as a person, and to perceive him as only a problem to be dealt with.

Administrative caution may well be the underlying reason why neither cost nor quality is controlled. To an outsider, the reason for want of control may seem humorous: One administrator, replying to a question, said that he keeps a "firm grip on costs" by refusing many of the requests for new equipment submitted by junior residents—a short-sighted view of cost control.

Of greater importance of course is quality control. There is no reason to believe that medical doctors cannot be good, bad and indifferent. All medical care providers should work under a control system to upgrade the quality and quantity of their work, a system which is constantly moving and constantly adapting to conditions, in order to get the maximum amount of quality productivity for the minimum amount of cost. In the British system, as in the United States system, protectionism of the doctor is rampant.

Adherence to tradition. Despite all his good intentions, the British administrator or physician finds it difficult to break away from the way things have always been done. Hence efforts to build a modern system are faced with problems that are inherited from the old days.

Perhaps one of the most obvious examples is the general acceptance of the need for the "home visit." It was interesting to note that the responses to the question, "Why so many home visits?" were not directed to the philosophical question but rather to the mechanics. It was pointed out that fevered children have always been visited at home, that old people are cared for in their homes, and so on. The answer literally is, "That's the way we've always done it."

In many instances, it was recognized by physicians that bringing patients into medical centers makes a lot more sense than going out to see them in their homes. However, it was suggested that many home visits were made because of a fear that someone will report the doctor if he does not make house calls.

These problems of segmentation of the system and the lack of quality and quantity control all exist in the United States. It is disappointing that the British in a more controlled system have not yet conquered them.

Needed: Managerial Orientation

In several areas there seems to be something less than a complete understanding of management principles. Only in Northern Ireland has there been an attempt to integrate the planning function with the organizing and control functions necessary to implement plans.

Elsewhere, there are planning groups that are stoutly resisting any such integration. This arrangement very neatly permits the planning group to abdicate its responsibilities for making a program work, and the administrative group to blame poor planning.

Another needed management input is at the level of the ambulatory care center. There is little recognition of the role that can be played by professional management here. However, when professionalism does make itself evident, there is a great demand. In one instance, for example, a health center engages in the practice of training a health service nurse as an administrator. The problem is that, as soon as one becomes trained and effective, higher authority steals her away.

Systems thinking. A systems approach toward health care delivery would preclude the British orientation toward massive hospital facilities. In general, large hospitals are more efficient than small ones in delivering hospital care; but the areas served by them are also large, which leads to "dehumanization" and, hence to ineffective service to the people in their service areas. The end result of course is a less effective total system. Even among people who express a favorable attitude toward the concept of localized health care delivery, there seems to be a bias against small hospitals. The emphasis is on maximizing the single element of a system—the hospital—rather than the the system as a whole. It appeared from our observations, however, that having more small hospitals and more services in the ambulatory care centers would save time for both the consumer and the provider and raise the general level of health care for the system as a whole.

This is not to suggest that systems planning is a panacea. Rather, it is a systematic inquiry into objectives, goals, standards and resources, and the most effective combination of these resources into a total system.

General Management and Marketing

Management thinking in the British system needs to be oriented toward cost control, particularly with regard to production control. Doctors under the system are paid according to the number of patients on their panel. This is, in itself, good, but there is no outside control exercised over either the quantity or the quality of their practice.

Better management could lead to better use of equipment and office space. Although doctors use their facilities only a portion of each day, there is no attempt to share. Rather, each doctor has his own examination room-office; and in addition a good deal of space is given to hallways, staff lounges and the like.

The British system of health care delivery needs a marketing strategy. First, an effort should be made to identify the needs of the market—that is, the consumers. Do the consumers want or will they use the services provided? Are the services appropriate for that market? One cannot but wonder whether this system was developed by the provider and then prescribed like a medication to the consumer. An effort to involve the consumer in the design of the system is not apparent.

Another marketing function, health education, including public relations or advertising, appears not to have been extensively used in a system which should make maximal use of it. In this context, we are not thinking of health education in the traditional disease-oriented sense but in relation to making both the consumer and the provider aware of the best way to make the best use of the system.

Proper marketing would be a major contribution to a cost-effective system and at the same time raise the level of health of the population. As it is, it is difficult to believe that the British system—working the way it does—could actually care for the total population if that population were utilizing as it should the primary care and health maintenance services. It might well be that the system is only serving those who recognize their illness, know about the available care, and can reach it.

The lack of management conceptualization and application is obvious. First, there is no integration between planning and doing—a basic principle of management. Second, there is very little attention paid to the cost-effective organization of personnel, facilities, and equipment. Third, the concept of systems management is lacking. Finally, no apparent attempt has been made to apply modern marketing techniques to the system.

Summary of the Pros and Cons

The British system through the establishment of certain controls has made better distribution of medical care, both geographically and by specialty, than has been accomplished in the United States. The British have come a long way toward solving the problems of "undoctored" areas and the problems of needless overspecialization that still exists in the United States. The average person has more ready access to physicians and, most important, the economic barrier between the doctor and patient has been removed. Care is fully paid for and physicians can be readily located. Both the doctor and the patient feel that they are better off under the British program as it operates today than they

were before the program was begun, in 1948. In general, the doctor has more to work with, has the support of his colleagues, and enjoys a more financially stable and professionally rewarding career. The consumer has readier access to health care without the fear of economic disaster as the result of sickness.

The whole British program represents a radical thrust on the part of the government to effect a change without the half-hearted, half-way measures we are experiencing and are liable to experience in the future.

On the adverse side, there are important problems which could be remedied. The system is slow, cumbersome, bureaucratic and tradition-bound. There is little input of modern management techniques, particularly in the integration of planning with actual operations and the application of general management and systems techniques. Although the system is dominated by the doctor providers, those basic providers have had little to do with the design of facilities or their use. While bowing to the preconceived and poorly tested traditional idea of the role of the doctor in control of health care delivery, those who manage the system have at the same time not allowed the doctor to join in implementing improvements in his effectiveness. Continuing the doctor in the traditional dual role of both manager and production worker can only deprive the system of quality and quantity control.

The very basic business of finding out what the market wants in a product or service before designing or providing it, has been ignored. Nothing is being done to sell the objectives and goals of the system to the consumer and to the provider. The total concept of cost effectiveness is poorly understood. Instead of design of the system as a whole for long-range cost effectiveness, there are short-range, piecemeal efforts that can only lead in the end to a more costly system. Although the British system has gone much further in developing a logical health care delivery program than the United States, it does not yet have a cost-effective total system responsive to all elements, including providers, consumers, and government.

Lessons for the United States

The British put their system together without due regard for management principles. Here in the United States, where we possess managerial skills in abundance, there can be no excuse for repeating British mistakes—we should apply our skills initially and continually.

Whatever our system, it should not replay the British tune. Rather, it should establish and work toward a common set of goals. Planning should be integrated with system operations. Control should be exercised to see that goals are achieved. The effectiveness of the total system should not be sacrificed to achieve a maximum effectiveness for one element in it.

A serious British error is their lack of control over quantity and quality of output. We have traditionally made this mistake, depending on some sort of cost control through price resistance in the marketplace or through insurance carriers' manipulation of benefits—controls that have obviously failed. In the United States we may do well to regard the British demonstration as an object lesson in the need for managerial control.

Marketing research techniques should be applied, first, to generate inputs as to need from both providers and consumers of medical care and, second, through aggressive marketing communication techniques to persuade both providers and consumers to utilize their system in the most productive manner possible.

The British have achieved a far superior geographic balance of medical care delivery than we have, as well as a better balance between the services of the general practitioner and the specialist. We should examine carefully their systems of monetary incentives and licensing to determine whether some features can be adapted to our context. Another British accomplishment, the amalgamation of community health services and ambulatory medical care, can also point the way for us. There is no fundamental justification for keeping these two elements of medical care delivery separated. Finally, it should be evident to us that our health care delivery system should not try to maintain a "cottage industry" approach to medical care. Despite British attempts to preserve the traditional one doctor-one office-one patient idea, pressures have become too great to resist and the structure is moving toward localized group practices.

In summary, Britain's experience highlights the need for us to apply our managerial and marketing expertise to the delivery of health care, the need to amalgamate all health care services, and—perhaps most important—the need to profane some sacred cows in the pastures of American medicine.